RESEARCH PROPOSAL

EFFECTS OF CBT & SEX THERAPY ON PSYCHOSEXUAL FACTORS AMONG PATIENTS WITH PREMATURE EJACULATION

For Registration to the Degree of Doctor of Philosophy

IN THE FACULTY OF ARTS & SOCIAL SCIENCES

IIS (DEEMED TO BE UNIVERSITY), JAIPUR

Submitted by

Mahi Khandelwal
ICG/2018/26588

Under the Supervision of

Dr. Sudha Rathore
Assistant Professor

Department of Psychology

August 2019

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CHAPTER-1

INTRODUCTION

Sexual dysfunction refers to a problem that prevents the individual or couple from experiencing satisfaction from sexual activity. Some 43 percent of women and 31 percent of men report some degree of sexual dysfunction. It also refers to a problem occurring during any phase of the sexual response cycle that prevents the individual or couple from experiencing satisfaction from the sexual activity (Hazimouratidis & Hatzichristou, 2007).

The sexual response cycle traditionally includes excitement, plateau, orgasm, and resolution. Desire and arousal are both part of the excitement phase of the sexual response. While research suggests that sexual dysfunction is common (43 percent of women and 31 percent of men report some degree of difficulty), it is a topic that many people are hesitant to discuss. Because treatment options are available, it is important to share your concerns with your partner and healthcare provider (Pereira et al., 2013).

Sexual dysfunction generally is classified into four categories:

- Desire disorders —lack of sexual desire or interest in sex
- Arousal disorders —inability to become physically aroused or excited during sexual activity
- Orgasm disorders —delay or absence of orgasm (climax)
- Pain disorders — pain during intercourse

Sexual dysfunction can affect any age, although it is more common in those over 40 because it is often related to a decline in health associated with aging. (Kockott, 2007)

The symptoms of sexual dysfunction are:

In men:

- Inability to achieve or maintain an erection suitable for intercourse (erectile dysfunction)
- Absent or delayed ejaculation despite adequate sexual stimulation (retarded ejaculation)
- Inability to control the timing of ejaculation (early or premature ejaculation)

In women:

- Inability to achieve orgasm
- Inadequate vaginal lubrication before and during intercourse
- Inability to relax the vaginal muscles enough to allow intercourse

In men and women:

- Lack of interest in or desire for sex
- Inability to become aroused
- Pain with intercourse

Various Causes of Sexual Dysfunctions are:

- **Physical causes** — many physical and/or medical conditions can cause problems with sexual function. These conditions include diabetes, heart and vascular (blood vessel) disease, neurological disorders, hormonal imbalances, chronic diseases such as kidney or liver failure, and alcoholism and drug abuse. In addition, the side effects of some

medications, including some antidepressant drugs, can affect sexual function. Hazimouratidis & Hatzichristou, (2007).

Psychological causes — these include work-related stress and anxiety, concern about sexual performance, marital or relationship problems, depression, feelings of guilt, concerns about body image, and the effects of a past sexual trauma.

Sexual Dysfunction and Psychology:

Sexual dysfunction often has deep psychological roots. This is not to say those afflicted by sexual dysfunction are imagining everything; it just means that our beliefs and attitudes truly do affect our reality. There are most certainly physical causes for the disorder as well, since often sexual dysfunction in an individual is caused by several different factors which interact to produce the difficulty. Treating sexual dysfunction is definitely a multi-faceted approach, but understanding the deeply held emotional reactions of a patient toward sex can be the key to unlocking their difficulties in the bedroom.

How it develops:

Sexual dysfunction can often be traced back to a patient's upbringing. Religion and culture play a very important role in defining who we are as we develop, and those rose in very strict religious families, or in cultures with punitive attitudes toward sex, often suffer from problems related to sexual functioning in adulthood (Hawton K, 1989). If we hold a very deep-set belief that what we are doing is wrong or dirty, then how can we possibly find enjoyment in that activity? If sex has always been associated in the mind with deviant behavior or punishment, it will be difficult to engage in sexual activities without a deep sense of guilt and shame – let alone actually enjoy it. For victims of sexual abuse, these beliefs can

be particularly hard-wired and damaging. (Hazimouratidis & Hatzichristou, 2007). It is important to seek therapy and heal from past events, and learn to accept sex as a loving and nurturing behavior rather than a traumatic and abusive experience.

- Treating sexual dysfunction often involves confronting these beliefs and changing attitudes toward sex so that it is viewed in a positive light, as a reflection of the love and intimate bond between a couple. These beliefs can function as an emotional wall in your relationship, separating you both psychologically and physically from your partner.

Sexual dysfunction & Psychotherapy

Sexual problems do not always require specific psychotherapy. If missing or wrong sexual information is the main cause, sexual counselling can be sufficient. We define "sex-psychotherapy" as the methods which are based on Masters and Johnson as well as other symptom-focused and experience- oriented (exercise) psychotherapeutic methods for sexually disturbed couples and singles (Maters & Jhonson, 1983). These methods have significantly improved the treatment of sexual dysfunctions. In group- and in couple-settings they have proven to be effective in reducing sexual symptoms and improving sexual satisfaction and partnership-satisfaction. Long-term studies showed that sex-psycho- therapy leads to a stable improvement in sexual satisfaction, whereas the reduction of sexual symptoms is less stable. (Wolpe, 1973) Therefore sex-psychotherapy should be combined with "Cognitive Behaviour therapy". A number of sexual disorders are caused by psychological and organic factors; they need both psychotherapy and medical treatment. This is of special importance in elderly men and in women with symptoms of **premature**

ejaculation. The success of treatment for sexual dysfunction depends on the underlying cause of the problem. The outlook is good for dysfunction that is related to a condition that can be treated or reversed. Mild dysfunction that is related to stress, fear, or anxiety often can be successfully treated with counselling, education, and improved communication between partners. (Pubmed, 1056; Web of Science, 200; Psycinfo, 163).

Premature Ejaculation:

Premature ejaculation can be annoying. Sometimes a couple can't even engage in intercourse, because ejaculation takes place so quickly. In some cases, a couple may have trouble getting pregnant. Women complain about being able to have an orgasm. So yes, premature ejaculation is a real problem (Serefoglu et al. 2011).

On the other hand, a lot of people who call for help don't have the problem they think they have. For example, men sometimes call because their partner doesn't have orgasm during intercourse. Yet the man is able to engage in intercourse for five minutes or longer. I've even had men tell me they last 15 minutes, which they consider to be "premature."

That is definitely NOT premature ejaculation. Just for the record, the official term for the condition is now "early ejaculation," so that's how we refer to it. Early ejaculation is diagnosed when a man ejaculates, or comes, within two minutes or less. It is not diagnosed when a woman cannot have an orgasm in the same time period.

If a person has really do have early ejaculation, there are a number of things that can help you. Unfortunately, men with early ejaculation seem to be especially preyed upon on the Internet with jacked up formulas, creams, sprays, and so on. By the time they get around to calling a professional, they tend to be understandably suspicious.

Screening Checklists

Screening checklists can provide a valuable resource in identifying and assessing sexual problems in men and women. Sexual problem identification should be regarded as an expected and routine aspect of health care for both men and women. This principle is applied especially for individuals at risk, such as men or women during visits for relationship problems, psychological or psychiatric problems (e.g. anxiety and depression) or major life changes (e.g. divorce, child birth), as well as in the presence of any chronic illnesses or medical conditions. The depth and extent of sexual inquiry should be individualized, based on person's background characteristics, risk factor profile and clinical occasion or type of visit. These simple assessment tools have the major benefits of providing cost-efficient identification of the problem, as well as preliminary assessment of current and past sexual functioning. Screening checklists are not constructed to be used as an aggregated scale and should be noted that both available screeners are not yet psychometrically tested for its construct, reliability or validity. Consensus-based screeners have been identified and developed by consensus panels of experts, the ICSM committee on diagnosis and scales and the second one by the Standards Committee of the ISSM.1,2 It should be emphasized that, although valuable in recognizing and identifying sexual dysfunction, screening tools such as these should not under any circumstances be substituted for a comprehensive sexual, medical and psychosocial history. Moreover, further evaluation of these symptoms is always recommended (and required) prior to initiating sexual therapy. The **Brief Sexual Symptom Checklist for Men** (BSSC-M) and **Women** (BSSC-W) consists of four simple questions and was developed for use in primary care settings, as well as for screening purposes, and addresses in both men and women the level of satisfaction with sexual function (the major outcome measure in sexual health). In addition, the screener can be used to assess the duration (chronicity) , and specific type/s of sexual problems experienced, as well as the

willingness of the individual to discuss the problem with a healthcare provider. Three of the four questions are common for men and women, while the fourth question (type of problem) is specific for each gender. More recently, the Sexual Complaints Screener for Men (SCS-M) and Women (SCS-W) has been developed by the Standards Committee of the International Society for Sexual Medicine. It is a comprehensive self-report screener for sexual dysfunction that can be easily and quickly administered by non-specialized clinicians and addresses all domains of sexual dysfunction, including distress. The screener intends to cover sexual desire/interest, objective and subjective arousal, orgasm, pain, vaginismus, persistent genital arousal disorder and satisfaction with one's sex life. This brief, self-administered screener is neither sufficiently detailed for obtaining an adequate diagnosis, nor is it constructed to provide end points for specific clinical trials. The SCS consists of a series of questions concerning sexual experiences during the last six months. The use of symptom scales and questionnaires in sexual health is accepted into everyday practice, as sexual problems have the essential characteristic of being self-reported conditions, with potentially major impact on psychosocial and emotional well-being, while in many cases there may be no biological findings. Therefore, the use of self-administered symptom scales has become essential not only in sex research, but it has been applied extensively in everyday clinical practice in many settings. Sexual dysfunction, according to recent definitions, exists when satisfaction arising from the integrated components of sexual function is reduced or absent. Therefore, outcomes assessment questionnaires are essential not only to determine reduction of distress or resolution of symptoms, but also to assess the overall well-being sexual or otherwise of the individual.

Various types of Psychotherapy in Sexual Dysfunction

Sex Therapy

Sex therapy is a specialized form of psychotherapy that draws upon an array of technical interventions known to effectively treat male and female sexual dysfunctions. Current sex therapy comprises a synthesis of the perspectives outlined above (Althof, 1994). Psychosexual therapy comprises cognitive-behavioral interventions, systems/couple interventions and sometimes psychodynamic interventions. These are often combined with medical therapy, thus providing care through a biopsychosocial perspective. The goal of treatment is the restoration of lasting and satisfying sexual function. With the multiple psychogenic factors that may underlie sexual dysfunctions, the need to consider the complex interplay of multiple factors is especially important in today's clinical sexology.

Components of an Integrative, Biopsychosocial, Multidimensional Model of Sexual Dysfunction.

Biological factors: physiologic dimensions of sexual function: vascular, neurologic, hormonal and lifestyle

Psychological dimensions (CBE);

- **Cognitions**: assumptions; beliefs or standards; perceptions; attributions; expectancies.
- **Behaviors**: actions.
- **Emotions**: feelings, e.g. confidence; resentments

Relationship dimensions (ICI):

Identity: relationship cognitions, e.g. couple expectations such as autonomy, cohesion, commitment.

Cooperation: interactions, e.g. mutual conflict resolution.

Emotional intimacy: relationship feelings, especially empathy.

Psychosexual skills: cognitive, behavioral, emotional and interpersonal aspects of lovemaking. Psychosexual therapy employs many of the basic principles other therapeutic modalities use in mental health, but it is unique in that it is an approach developed specifically for the treatment of sexual problems. That is, sex therapy is a specialized form of treatment that focuses on one aspect of the wide range of human problems. Sex therapy techniques, when applied by an unskilled therapist, might focus too much on mechanical sexual behavior, to the exclusion of the total individual and the total relationship. Instead, it represents a unique alchemy of the patient, the couple and the therapist, influenced by "chance events," client motivation, contextual components and favorable timing.

CBT for Sexual Disorders

Cognitive Behavioral Therapy (CBT) is the most effective psychological treatment for a variety of psychological problems, including depression, anxiety disorders and sexual dysfunction. CBT has been successfully applied to sexual problems (mainly sexual dysfunctions) during the last three decades and some treatment manuals have been developed. The core features of CBT for sexual problems, including its rational, evidence-based models and treatment outcome studies. Here we will start by reviewing the studies on the role of cognitive and behavioral factors on sexual problems, providing important information based on scientific evidence about the cognitive and behavioral processes involved in sexual disorders (Bagcioglu; Altunoluk; Bez; Soylemez, H; Asik, & Emul, (2012). We will then describe evidence-based psychological models of sexual dysfunction, with particular emphasis on the cognitive and emotional models (e.g. Barlow's Cognitive-Affective Model and Nobre's Cognitive-Emotional Model). Following this, we will present a

rational and detailed description of the main components of cognitive behavioral treatments for sexual disorders. The role of psychological factors on sexual dysfunction has resulted in a better understanding of their role in the last few decades. Among the most studied variables are dispositional variables, such as personality, affect and sexual inhibition, sexual beliefs, cognitive schemas, automatic thoughts 16 and emotions.

Cognitive behavioral therapy (CBT) for sexual disorders is the application of cognitive and behavioral principles to the field of sexual problems. Therefore, CBT for sexual disorders uses treatment strategies similar to those for other psychological disorders. Before starting treatment, it is very important to conduct a thorough assessment of the sexual difficulties and related problems (as described above). (Salam; Sharma; Prakash, 2019)**.** In particular, therapists should collect rigorous and complete information on the following topics: 1. relevant information in order to assign a reliable multiaxial diagnosis 2. Information about the possible predisposing factors (e.g. sexual and life experiences, family and sexual education, sexual and interpersonal relationships) and precipitating aspects (life events that occur at the time of the beginning of difficulties) of sexual dysfunction 3. Information about the current difficulties and their maintenance factors (e.g. severity of the problem, precedents and consequents of the problem, and conditions that intensify and relieve). After this information is collected and case formulation is completed, the therapist should give feedback to the patient, explain the CBT rationale and discuss the treatment plan. Most cognitive behavioral treatment protocols for sexual dysfunction use a common list of intervention techniques. The main components used are (a) sensate focus, (b) stimulus control, (c) sexual skills training and (d) cognitive restructuring (Salam; Sharma; Prakash, 2019). We will present the main objectives and processes involved in these techniques, with special emphasis on cognitive restructuring.

Love Attitude

Love Attitude is a psychological construct, a mental and emotional entity that inheres in, or characterizes a person. They are complex and are an acquired state through experiences. It is an individual's predisposed state of mind regarding a value and it is precipitated through a responsive expression towards a partner, place, thing, or event (the attitude object) which in turn influences the individual's thought and action towards each other partner. These love style may change over a lifetime, but not always. These different categories of love attitude give a sense of the kind of lover you tend to be and how it effects sexual intimacy between couples and PE, even if you are not in a relationship right now. If someone is in a relationship, love attitude help describe what you are like and how you behave in that relationship.

Researchers have studied the way people express and experience romantic love. The sociologist Lee (1973) became very well known for his classification of love styles, also called the *colors of love*. The six love styles are listed below (Hendrick & Hendrick, 1986):

Six Greek words for different kinds of love.

Eros stands for passionate love. In researching this test, the authors found that people who reported that they are currently in love were particularly likely to be identified with Eros. Eros involves strong physical preferences and responses to a lover, and a lot of commitment is involved. Eros was the most common feeling among respondents in recent research on Love Attitudes.

Ludus stands for game-playing love. People who score high in this category approach love as an interactional game - even if it sometimes involves deception. Ludus types may even be wary of closeness. Men were more likely to approach love as a game, although men and

women were pretty similar in this regard. People who have never been in love and those who have been in love again, and again, and again tended to fit well into this category, while people who have been in love only once or twice were not as likely to belong in this category. Ludus was the least common feeling among respondents in recent research.

Storge, is an inclination to link love and friendship. It is an enduring kind of love, but it is not a particularly passionate kind of love. Storge was less common than Eros, but much more common than Ludus in recent research.

The next three types are subtypes that reflect how we behave regarding your feelings.

Pragma, means someone is a rational thinker. We focus on finding a lover who has the kind of qualities that you prefer; we may even have a plan about the ideal relationship before you find the lover of your dreams. Among the second set of love attitudes, Pragma was the least common.

Mania may be what is somstimes called puppy love - since it is particularly common among adolescents (although plenty of older lovers can be manic). There is a high degree of uncertainty about the lover and a lot of activity around seeking to fix that uncertainty.

Agape is rare in its purest form, although it received the highest score among the second three Love Attitudes. agape is selfless love, the kind that involves giving without taking, and may only appear in its true form in parents of small children - and then perhaps only on occasion

Lee (1973/1976) identified three primary types of love styles: Eros (romantic, passionate love), Ludus (game-playing love), Storge (friendship love), and three main secondary styles: Mania (possessive, dependent love), Pragma (logical, "shopping list" love), and Agape (all-

giving, selfless love). These secondary styles were conceived as compounds of pairs of primary styles. Analogous to chemical compounds, the secondary styles are qualitative transformations of the "base primary elements." Thus, Mania is a compound of Eros and Ludus, but Mania is qualitatively very different from either primary. In the same fashion, Pragma is a compound of Storge and Ludus, but has very different properties. The same holds true for Agape, a compound of Eros and Storge. One implication of the analogy to chemical compounds is that although the six love styles are logically interrelated, each style has qualitative properties inde- pendent of all of the other styles. Empirically, measures of these six love styles should be orthogonal to each other. In sum, the love styles are all equally valid ways of loving. There is no one type of love, but rather many different types.

Marital Adjustment

Marital adjustment has long been used to describe the quality and stability of marriage. A well-adjusted marriage is expected to last for a long time and be satisfying by both spouses. The quality of marital relationship has been found to be consequential for health. A poor marital relationship could influence physiological functions and impact health outcomes through depression and health habits. The process during which partners in a marriage adapt and change to their new roles complementing each other acting as a team opposed to two separate units, it is also important to unify the following- interests and values, maintaining open lines of communication mentally and sexually and encouraging the expression of each other's communication. Marital adjustment, "shortly after 'tying the knot' the new couple will enter into marital adjustment where they will establish their place within the relationship found their feet in the new life." If the adjustment leads to some causes in their lifestyle then it can lead effect their sexual intimacy and can cause various sexual dysfunction.

Human sexuality being a central core of marital relationship and adjustment, it is intuitively understandable that male psychosexual dysfunction (e.g. erectile dysfunction, ejaculatory disturbance, or both) should be distressing for the spouses of the affected men. Many women, when faced with a partner's sexual dysfunction, assume either that they are no longer attractive or the man has developed an interest in other women. This negative self-evaluation, as well as the frustration caused by the male spouse's performance difficulties can interfere with communication, and may lead to the disintegration of the couple's relationship as well as impairment in psychosocial functioning of the female spouse. Although many couples may be able to adjust to sexual dysfunction, frequently, marriages are disrupted or ended as a result of sexual problems (Osborne, 1981). Inspite of this intuitive understanding, however, there is a striking paucity of research actually documenting the distress in wives of psychosexually dysfunctional males. This deficit is glaring in the face of the reportedly appreciable 9.2% to 13% of psychiatric outpatients and 30% of males attending STD clinic presenting with sexual dysfunction in India (Kar & Verma, 1978; Kumar et al.,1983; Catalan etal. 1981).

The relationship of distress experienced with marital adjustment and psychosocial dysfunction, it was indicated that greater the distress experienced by the wives of psychosexually dysfunctional patients, the more was the impairment in their psychosocial function and poorer was the marital adjustment. Moreover, poorer marital adjustment was also found to be associated with more psychosocial dysfunction.

Guilt

Sexual guilt or shame refers to a feeling of grave responsibility and deep remorse associated with participation in or even thoughts and fantasies about sexual activity. Individuals who feel guilt related to sex or particular sexual activities generally believe that

sex (or a specific sex act) is immoral, sinful or unclean. The understanding of guilt associated with sexual activities began with the work of the psychoanalyst Sigmund Freud. (Stuewig, J., Tangney, J., Kendall, S., Folk J., Meyer C., R., Ronda L., 2016). While many people, including many psychologists and psychiatrists, reject a Freudian approach, his ideas are of interest as a starting point for understanding sexual guilt. Freud maintained that libido, or the sexual instinct, is one of the core drives in human behavior and personality formation.

The understanding of guilt associated with sexual activities began with the work of the psychoanalyst Sigmund Freud. From birth, a child receives messages from its parents about what are and are not acceptable ways of expressing sexual desire, as well as messages about approved or disapproved attitudes toward sexual issues. These social hindrances on the free and open expression of basic desires contribute to the formation of three distinct aspects of the human personality, according to Freud. First, there is the id, a combination of the most primitive drives and the psychic energy needed to initiate actions designed to satisfy these desires, including the desire for sex. Next, there is the ego, which refers to an executive function in the human mind that takes in information from the body's sense organs about the external world and directs the day-to-day fulfillment of sexual and other desires in socially acceptable and achievable ways. Finally, there is the superego, consisting of the learned and internalized social standards of behavior received from parents and others, including an understanding of banned or punishable behaviors. The superego is our conscience; it consists of internally held values about what is right and commendable, on the one hand, and what is wrong and condemnable on the other. Transgression of superego standards leads to guilt feelings as well as to a sense of remorse, anger directed at oneself, and a loss of self-esteem. These transgressions need not be actual behaviors, such as participation in banned sexual activities. They may occur in dreams or fantasies as well. Sheikh S1, Janoff-Bulman R. (2009). While many people, including many psychologists and psychiatrists, reject a Freudian

approach, his ideas are of interest as a starting point for understanding sexual guilt. Freud maintained that libido, or the sexual instinct, is one of the core drives in human behavior and personality formation.

Recent studies have noted considerable levels of sexual guilt associated with masturbation among the elderly as well. In both instances, masturbation produces guilt because it is defined as an inappropriate behavior by adults or by society in general.

CHAPTER-II

REVIEW OF LITERATURE

Sexual dysfunction

Snell et al. (1993) studied titled "The multidimensional sexuality questionnaire: An objective self-report measure of psychological tendencies associated with human sexuality".The purpose of the study was to develop and validate an objective self-report instrument, the Multidimensional Sexuality Questionnaire (MSQ), designed to measure psychological tendencies associated with sexual relationships. Results indicated that the MSQ subscales had high internal consistency, test-retest reliability, and were largely independent of social desirability tendencies. Other results indicated that women and men responded in unique ways to the MSQ, with women reporting greater sexual-fear and men reporting greater sexual-esteem, sexual-preoccupation, sexual-motivation, sexual-assertiveness, and external-sexual-control. Additional evidence for the concurrent, discriminant, and convergent validity of the MSQ was found: the MSQ was associated not only with women's and men's sexual attitudes and their exchange and communal approaches to sexual relations, but also with their scores on other instruments conceptually similar to the MSQ. Men's and women's sexual behaviors were also predictably related to their scores on the MSQ subscales.

Clayton AH, Kingsberg SA, Goldstein I. (2018) examined the "Evaluation and Management of Hypoactive Sexual Desire Disorder". Hypoactive sexual desire disorder (HSDD) often has a negative impact on the health and quality

of life of women; however, many women do not mention—let alone discuss—this issue with their physicians. Providers of gynecologic services have the opportunity to address this subject with their patients. The aim of the study is to review the diagnosis and evidence-based treatment of low sexual desire in women with a focus on strategies that can be used efficiently and effectively in the clinic. Methods used were the Medline database was searched for clinically relevant publications on the diagnosis and management of HSDD. The results came out to be HSDD screening can be accomplished during an office visit with a few brief questions to determine whether further evaluation is warranted. Because women's sexual desire encompasses biological, psychological, social, and contextual components, a biopsychosocial approach to evaluating and treating patients with HSDD is recommended. Although individualized treatment plan development for patients requires independent medical judgment, a simple algorithm can assist in the screening, diagnosis, and management of HSDD. Once a diagnosis of HSDD has been made, interventions can begin with office-based counseling and progress to psychotherapy and/or pharmacotherapy. Flibanserin, a postsynaptic 5-hydroxytryptamine 1A agonist and 2A antagonist that decreases serotonin levels and increases dopamine and norepinephrine levels, is indicated for acquired, generalized HSDD in premenopausal women and is the only agent approved in the United States for the treatment of HSDD in women. Other strategies to treat HSDD include using medications indicated for other conditions (eg, transdermal testosterone, bupropion). Bremelanotide, a melanocortin receptor agonist, is in late-stage clinical development. Conclusions were Providers of gynecologic care are uniquely positioned to screen, counsel, and refer patients with HSDD. Options for pharmacotherapy of HSDD are currently limited to flibanserin, approved by the US Food and Drug Administration, and off-label use of other agents.

Reseachers studied titled “Effects of expressive writing on sexual dysfunction, depression, and PTSD in women with a history of childhood sexual abuse: results from a randomized clinical trial” done by **Meston, C. M., Lorenz, T. A., & Stephenson, K. R. (2013)**. Women with a history of childhood sexual abuse (CSA) have high rates of depression, post-traumatic stress disorder, and sexual problems in adulthood. The aim of the study was to test an expressive writing based intervention for its effects on psychopathology, sexual function, satisfaction and distress in women who have a history of CSA. Main Outcome measures were validated self-report measures of psychopathology and sexual functions were conducted at post-treatment, 2 weeks, one month, and six months. Methods used were seventy women with CSA histories completed five 30-minute sessions of expressive writing, either with a trauma focus or a sexual schema focus. Results obtained that women in both writing interventions exhibited improved symptoms of depression and posttraumatic stress disorder (PTSD). Women who were instructed to write about the impact of the abuse on their sexual schema were significantly more likely to recover from sexual dysfunction. Conclusions were expressive writing may improve depressive and PTSD symptoms in women with CSA histories. Sexual schema-focused expressive writing in particular appears to improve sexual problems, especially for depressed women with CSA histories. Both treatments are accessible, cost-effective, and acceptable to patients.

Pulverman C.S., Kilimnik C.D., Meston C.M. (2018), examined “The Impact of Childhood Sexual Abuse on Women's Sexual Health:A Comprehensive Review”**.** The aim of the study is to summarize the most up-to-date research on the relation between CSA and women's sexual function. Methods used were the published literature examining the prevalence of sexual dysfunction among women with CSA

histories, various types of sexual dysfunctions, and mechanisms proposed to explain the relation between CSA and later sexual difficulties was reviewed. Main outcome measures were review of peer-reviewed literature. Results obtained that women with abuse histories report higher rates of sexual dysfunction compared with their non-abused peers. The sexual concerns most commonly reported by women with abuse histories include problems with sexual desire and sexual arousal. Mechanisms that have been proposed to explain the relation between CSA and sexual dysfunction include cognitive associations with sexuality, sexual self-schemas, sympathetic nervous system activation, body image and esteem, and shame and guilt. Conclusions were that women with CSA histories represent a unique population in the sexual health literature. Review of mechanisms proposed to account for the relation between CSA and sexual health suggests that a lack of positive emotions related to sexuality, rather than greater negative emotions, appears to be more relevant to the sexual health of women with CSA histories. Treatment research has indicated that mindfulness-based Sex therapy and expressive writing treatments are particularly effective for this group. Further research is needed to clarify the mechanisms that lead to sexual dysfunction for women with abuse histories to provide more targeted treatments for sexual dysfunction among women with abuse histories.

Chokka, P. R., & Hankey, J. R. (2017) evaluated Assessment and management of sexual dysfunction in the context of depression. Sexual dysfunction (SD) is pervasive and underreported, and its effects on quality of life are underestimated. Due in part to its bidirectional relationship with depression, SD can be difficult to diagnose; it is also a common side effect of many antidepressants, leading to treatment noncompliance. While physicians often count on patients to spontaneously report SD, treatment is optimized when the clinician instead performs a

thorough assessment of sexual functioning before and during drug therapy using a standardized questionnaire such as the Arizona Sexual Experiences Scale (ASEX). Separating the effects of the disorder from those of medications is challenging; we present a concise, evidence-based schematic to assist physicians in minimizing treatment-emergent sexual dysfunction (TESD) while treating depression. Vascular, hormonal, neurogenic, and pharmacological factors should be considered when a patient presents with SD. We also recommend that physicians obtain patient information about baseline and historical sexual functioning before prescribing a drug that may lead to SD and follow up accordingly. When the goal is to treat depression while attenuating the risk of sexual symptoms, physicians may wish to consider agomelatine, bupropion, desvenlafaxine, moclobemide, trazodone, vilazodone, and vortioxetine.

Salmani, Z., Zargham-Boroujeni, A., Salehi, M., K Killeen, T., & Merghati-Khoei, E. (2015). The existing therapeutic interventions for orgasmic disorders: recommendations for culturally competent services, narrative review. In recent years, a growing number of interventions for treatment of female orgasmic problems (FODs) have emerged. Whereas orgasm is a extra biologically and learnable experience, there is a need for practitioners that to be able to select which therapy is the most appropriate to their context. The aim of the study is to literature review, we aimed to assess areas of controversy in the existing therapeutic interventions in FOD with taking into accounted the Iranian cultural models. Materials and Methods used were for the study, they conducted an extensive search of electronic databases using a comprehensive search strategy from 1970 till 2014. This strategy was using Google Scholar search, “pearl-growing” techniques and by hand-searching key guidelines, to identify distinct interventions to women's orgasmic problem therapy. We utilized

various key combinations of words such as:" orgasm" OR "orgasmic "," female orgasmic dysfunction" OR Female anorgasmia OR Female Orgasmic Disorder ", orgasmic dysfunction AND treatment, “orgasm AND intervention”. Selection criteria in order to be included in this review, studies were required to: 1 employ clinical-based interventions, 2 focus on FOD. Results obtained were the majority of interventions (90%) related to non-pharmacological and other were about pharmacological interventions. Self-direct masturbation is suggested as the most privilege treatment in FOD. Reviewing all therapies indicates couple therapy, sexual skill training and sex therapy seem to be more appropriate to be applied in Iranian clinical settings. Conclusion came since many therapeutic interventions are introduced to inform sexually-related practices, it is important to select an intervention that will be culturally appropriate and sensitive to norms and values. Professionals working in the fields of health and sexuality need to be sensitive and apply culturally appropriate therapies for Iranian population. They further suggest community well defined protocols to screen, assessment and management of women’ sexual problems such as FOD in the Iranian settings.

Metz et al. (2008) Reviewed that the most common male sexual dysfunction, premature ejaculation (PE). There are two basic kinds of PE: biogenic and psychogenic. The prevalence, classification, neurophysiology, neuropharmacology, and psychological studies evidence useful for understanding and clinically evaluating PE are reviewed. It was proposed that studies reporting pharmacological aspects of ejaculation offer some suggestions regarding the mechanisms of ejaculation as well as possible pharmacologic aid for some premature ejaculators. They reviewed that the traditional assumption among sex therapists that PE is almost universally caused by four psychological features, and easily treated with

sex therapy, behavioural techniques. Based on the limited available results from systematic investigations, behavioural treatments for PE remain beneficial to only a minority of men three years after treatment ends, suggesting that this male dysfunction is difficult to treat effectively. The mediocre results reported in treatment outcome studies may be due, in part, to reports on heterogeneous groups of premature ejaculators, for whom treatment has been generalized rather than targeted to the specific type of PE. With more discriminating assessment and more specific diagnosis of PE, and with treatment designed to address the particular type of PE, long–term outcome should improve for this common sexual dysfunction.

Anxiety is the most common intrapsychic component in male sexual dysfunction **(Bagcioglu et al. 2012)** evaluated in their study titled "Metacognition in patients with premature ejaculation and erectile dysfunction "that metacognition is considered to be the way of thinking about "thinking" which could be associated with anxiety. The aim of the study was to investigate the metacognition level of patients with premature ejaculation. Forty patients with premature ejaculation and 40 with erectile dysfunction, and a matched number of healthy people participated. Participants were asked to fill out Meta-cognitions Questionnaire-30, Beck Depression and Beck Anxiety Inventories. The total metacognition score was significantly higher in patients with premature ejaculation ($p<.05$) and erectile dysfunction ($p<.05$) than healthy controls. Total metacognition score was not significantly differed between sexual disorder groups ($p >.05$). The positive beliefs, negative beliefs scores were significantly higher in patients with sexual disorders ($p <.05$). The cognitive self consciousness score was significantly higher in patients with premature ejaculation than erectile dysfunction group ($p <.05$) and healthy controls ($p <.05$). Patients with sexual disorders might endorse the metacognitive belief that

worrying about worriable problems can have positive effects in solving problems and avoiding unpleasant situations, which may be associated with sexual disorder

Pereira et al. (2013) , aimed to evaluate about 45% of women suffer from some form of sexual dysfunction. Despite its high prevalence, there are few studies that have systematically evaluated sex therapy in comparison with other interventions. The objective of the study was to review randomized clinical trials that present psychotherapeutic interventions for female sexual dysfunctions. Method used through a search in three databases (Medline, Web of Science and PsycInfo), 1419 references were found. After an analysis of the abstracts, twenty-seven articles met the inclusion criteria and composed this review. The results came that sex therapy, as proposed by Masters and Johnson and Heiman and LoPiccolo, is still the most commonly used form of therapy for sexual dysfunctions; although it has shown results, the results do not consistently support that this is the best alternative in the treatment of sexual dysfunctions. They concluded that here is a lack of systematic study of many female sexual dysfunctions. Orgasmic disorder and sexual pain (vaginismus and dyspaurenia) are the most extensively studied disorders and those in which sex therapy seems to have better outcomes.

Premature Ejaculation

Serefoglu et al. (2013) examined Premature ejaculation (PE) is the most common sexual dysfunction, with the majority of PE patients remaining undiagnosed and undertreated. Despite its prevalence, there is a current paucity of data regarding available treatment options and mechanisms. The objective of the current investigation is to review and summarize pertinent literature on therapeutic options for the treatment of PE, including behavioral/ psychological, oral pharmacotherapy,

and surgery. The methods used a pubmed search was conducted on articles reporting data on available treatment options for PE. Articles describing potential mechanisms of action were additionally included for review. Preference was given towards randomized, controlled trials, when available. Results came that PE remains an underdiagnosed and undertreated disease process, with limited data available regarding potential underlying mechanisms and long-term outcomes of treatment options. Psychological/ behavioral therapies, including the stop-start, squeeze, and pelvic floor rehabilitation techniques have demonstrated improvements in short-term series, with decreased efficacy with additional follow-up. Alternative therapies such as acupuncture have shown benefits in limited studies. Surgery is not commonly performed and is not recommended by available guidelines.Conclusions: PE is a common condition, with limited data available regarding its underlying pathophysiology and treatment. Available therapies include topical, oral, behavioural/psychological modification, or a combination thereof.

A study titled "Premature ejaculation: therapist perspectives" done by **Brewer & Tidy** (2016), that the Premature ejaculation (PE) is a common sexual dysfunction affecting approximately 20%–30% of men. Despite important issues relating to PE definition, diagnosis, and therapy, there is a paucity of research investigating the experiences of practitioners delivering PE treatment. For the study, interviews were conducted with eight psychosexual therapists and subjected to interpretative phenomenological analysis. Four master themes emerged from the analysis. These were Romantic Relationships, Vulnerability, Culture, and Diagnosis and Assessment. The Romantic Relationships theme included three sub-themes: Intimacy; Involvement; and Distress. Two sub-themes formed the Vulnerability theme: Self-Esteem; and Anxiety. The Culture theme contained three sub-themes:

Religion and Ethnicity; Pornography; and Masculinity. The Diagnosis and Assessment theme included two sub-themes: Referral and Definitions. Findings have important implications for the diagnosis and treatment of PE. Future research should investigate therapist perceptions further, including those factors which impact on engagement with clients and PE treatment success.

The study titled “The comparison of premature ejaculation assessment questionnaires and their sensitivity for the four premature ejaculation syndromes: results from the Turkish society of andrology sexual health survey” examined by **Serefoglu et al. (2011)**, that in addition to the previously defined "lifelong" and "acquired" premature ejaculation (PE), the existence of two more subtypes of PE, namely "natural variable PE" and "premature-like ejaculatory dysfunction," has been proposed. The aim of the study is to evaluate the diagnostic value of the Premature Ejaculation Diagnostic Tool (PEDT) and Arabic Index of Premature Ejaculation (AIPE) in a population-based study, in relation to their sensitivity across these four different PE syndromes and to assess the Premature Ejaculation Profile (PEP) scores of patients with lifelong, acquired, natural variable PE and premature-like ejaculatory dysfunction. The methods used were between June 2009 and December 2009, couples were randomly selected from 17 provinces of Turkey. Subjects with the complaint of ejaculating prematurely were classified as lifelong, acquired, natural variable PE, and premature-like ejaculatory dysfunction according to the medical and sexual history they described. PE status was also assessed with PEDT, AIPE and PEP. The sensitivity, specificity, positive predictive value and negative predictive value were calculated for PEDT and AIPE in the study population whereas detection rates of these two questionnaires were also compared among the four PE syndromes. Moreover, PEP scores of patients with lifelong, acquired, natural variable PE and

premature-like ejaculatory dysfunction were compared. Significance level was considered as $P < 0.05$. The main outcome measures were Scores obtained from PEDT, AIPE, and PEP questionnaires. Results came out to be a total of 2,593 couples were enrolled where 512 (20.0%) male subjects reported PE. PEDT, AIPE, and PEP measures of the PE patients indicated worse sexual function ($P < 0.001$ each). Mean scores obtained from questionnaires were significantly better in patients with premature-like ejaculatory dysfunction and they were the worst in patients with acquired PE ($P < 0.001$ each). The sensitivity values of PEDT and AIPE were 89.3 and 89.5, whereas their specificity values were 50.5 and 39.1, respectively. There were statistically significant differences in detection rates of PEDT and AIPE among the four PE syndromes ($P = 0.006$ and $P < 0.001$). They were higher in acquired and lifelong PE and lower in premature-like ejaculatory dysfunction. The conclusion were PEDT and AIPE can diagnose PE with high sensitivity, especially in patients with lifelong and acquired PE. The complaint of patients with acquired PE seems to be more severe than those complaining of lifelong, natural variable PE and premature-like ejaculatory dysfunction patients.

Researchers **Serefoglu et al. (2011),** studied "Prevalence of the complaint of ejaculating prematurely and the four premature ejaculation syndromes: results from the Turkish Society of Andrology Sexual Health Survey. In addition to the previously known lifelong and acquired premature ejaculation (PE) syndromes, the existence of two more PE syndromes has been suggested: natural variable PE and premature-like ejaculatory dysfunction. However, epidemiological studies investigating the prevalence of these four PE syndromes have yet to be conducted. The aim of the study was to determine the prevalence of the complaint of ejaculating prematurely across the four PE syndromes. This study, conducted between June 2009 and December

2009, was designed as a non-interventional, observational cross-sectional field survey. Participating couples were randomly selected from 17 provinces of Turkey. All participants were asked to complete a questionnaire including data regarding demographics, socioeconomic status, social and cultural factors, medical and sexual history, current medications, and ejaculation time. Subjects with a complaint of ejaculating prematurely were classified as lifelong, acquired, and natural variable PE, or premature-like ejaculatory dysfunction. The main outcome measures were prevalence of complaint of ejaculating prematurely in the general population and across the four PE syndromes. RESULTS*:* A total of 2,593 couples (mean age, 41.9±12.7 years for males and 38.2±12.1 years for females) were enrolled. Five-hundred twelve subjects (20.0%) complained of ejaculating prematurely. Fifty-eight (2.3%), 100 (3.9%), 215 (8.5%), and 131 (5.1%) subjects were classified as lifelong, acquired, and natural variable PE, and premature-like ejaculatory dysfunction, respectively. CONCLUSIONS: The prevalence of the complaint of ejaculating prematurely among Turkish men was 20.0%, with the highest PE syndrome being natural variable PE (8.5%) and premature-like ejaculatory dysfunction (5.1%).

Kalejaiye O et al. (2017) examined study titled "Premature ejaculation: challenging new and the old concepts" that Premature ejaculation remains a difficult condition to manage for patients, their partners, and the clinician. Whilst prevalence rates are estimated to be 20–40%, determining a diagnosis of premature ejaculation is difficult, as the definition remains both subjective and ill-defined in the clinical context. As our understanding of the ejaculatory pathway has improved, new opportunities to treat the condition have evolved with mixed results. In this review, we explore some of these controversies surrounding the aetiology, diagnosis, and treatment of this condition and discuss potential novel therapeutic options. PE is a

common problem with variability in definitions and efficacy measures of drugs used for this condition. The real importance for future drug development is the unification of definitions of PE and an agreed standard for what are acceptable measures and inclusion criteria in the trial setting. There remains uncertainty in assessing the true value of some of the drugs we already use in the management of this condition. There are different definitions for PE, different efficacy measures, and poor methodology in clinical trials. In addition, the high discontinuation rates suggest that our patients remain dissatisfied with the treatments we currently offer. Furthermore, one must be cautious to define a pathological condition often associated with a high placebo effect. There are currently several novel agents who show promise for the future, but our optimism must be balanced against accepting suboptimal science and methodology in drug trials. PE continues to be the Cinderella of sexual medicine and requires funding and high-level research in both basic science and clinical trials. The oxytocin antagonists probably show the most future promise but data are still premature.

McMahon C. G. (2016). Studied titled "The design and methodology of premature ejaculation interventional studies". Large well-designed clinical efficacy and safety randomized clinical trials (RCTs) are required to achieve regulatory approval of new drug treatments. The objective of this article is to make recommendations for the criteria for defining and selecting the clinical trial study population, design and efficacy outcomes measures which comprise ideal premature ejaculation (PE) interventional trial methodology. Data on clinical trial design, epidemiology, definitions, dimensions and psychological impact of PE was reviewed, critiqued and incorporated into a series of recommendations for standardisation of PE clinical trial design, outcome measures and reporting using the principles of evidence based medicine. Data from PE interventional studies are only reliable, interpretable

and capable of being generalised to patients with PE, when study populations are defined by the International Society for Sexual Medicine (ISSM) multivariate definition of PE. PE intervention trials should employ a double-blind RCT methodology and include placebo control, active standard drug control, and/or dose comparison trials. Ejaculatory latency time (ELT) and subject/partner outcome measures of control, personal/partner/relationship distress and other study-specific outcome measures should be used as outcome measures. There is currently no published literature which identifies a clinically significant threshold response to intervention. The ISSM definition of PE reflects the contemporary understanding of PE and represents the state-of-the-art multi-dimensional definition of PE and is recommended as the basis of diagnosis of PE for all PE clinical trials

Gray, M., Zillioux, J., Khourdaji, I., & Smith, R. P. (2018). Examined "Contemporary management of ejaculatory dysfunction". Although erectile dysfunction is the most common disorder of male sexual health, ejaculatory dysfunction is the most common form of sexual dysfunction experienced by men. Ejaculatory dysfunction covers a broad range of disorders that we have divided into four main categories: premature ejaculation, delayed ejaculation (DE)/anorgasmia, unsatisfactory sensation of ejaculation (including painful ejaculation and ejaculatory anhedonia), and absent ejaculate (including retrograde ejaculation and aspermia). They also cover several special scenarios including hematospermia, spinal cord injury and fertility with anejaculation. In this paper, they will review the anatomy and pathophysiology of normal ejaculation to establish the baseline knowledge of how this pathway can go awry. We will then briefly review the critical diagnostic criteria, pertinent steps in evaluation, risk factors, and causes (if known) for each of the

ejaculatory disorders. Finally, the bulk of the paper will discuss current management strategies of each disorder.

Cayan, S., & Serefoğlu, E. C. (2014). Evaluated study titled "Advances in treating premature ejaculation". In spite of its high prevalence and long history, the ambiguity regarding the definition, epidemiology and management of premature ejaculation continues. Topical anesthetic creams and daily or on-demand selective serotonin reuptake inhibitor (SSRI) treatment forms the basis of pharmacotherapy for premature ejaculation today, in spite of low adherence by patients. Psychotherapy may improve the outcomes when combined with these treatment modalities. Tramadol and phosphodiesterase type 5 inhibitors have a limited role in the management of premature ejaculation. Further research is required to develop better options for the treatment of this common sexual disorder.

Goethe, V. E., et al. (2018). Examined "Concordance and Discordance of Sexual Identity, Sexual Experience, and Current Sexual Behavior in 45-Year-Old Men: Results From the German Male Sex-Study". To investigate concordant and discordant sexual behavior in 45-year-old German men with a special focus on homosexual identified men. Methods used were data for this cross-sectional study were collected within the German Male Sex-Study. Participants were 45-year-old Caucasian males from the general population. Men self-reported on sexual identity, sexual experience, and current sexual behavior. Associations between sexual identity, experience, and behavior were analyzed using the chi-square test. Main Outcome Measure were the associations of sexual identity with sexual experience and behavior in a community-based sample of men, and discordance of sexual identity and behavior especially in the subgroup of homosexual men. Results were 12,354 men were included in the study. 95.1% (n = 11.749) self-identified as heterosexual, 3.8%

(n = 471) as homosexual, and 1.1% (n = 134) as bisexual. Sexual identity was significantly associated with sexual experience and behavior. 85.5% of all men had recently been sexually active, but prevalence of sexual practices varied. In hetero- and bisexuals, vaginal intercourse was the most common sexual practice, whereas oral sex was the most common in homosexuals. A discordance of sexual identity was especially found in homosexual men: 5.5% of homosexuals only had sexual experiences with women, and 10.3% of homosexuals recently had vaginal intercourse. In this latter subgroup, only one-quarter ever had sexual experience with a man, and three-quarters had only engaged in sexual activity with a woman. Conclusion was that Sexual identity is associated with differences in sexual experience and behavior in German middle-aged men. A considerable proportion of homosexual identified men live a heterosexual life.

Hansen, N. B., Brown, L. J., Tsatkin, E., Zelgowski, B., & Nightingale, V. (2012). Study titled "Dissociative experiences during sexual behavior among a sample of adults living with HIV infection and a history of childhood sexual abuse". Little attention has been given to the occurrence of dissociative symptoms during sexual behavior in adults who have experienced childhood sexual abuse (CSA). For this study, 57 adults living with HIV infection who had experienced CSA and were entering a treatment study for traumatic stress completed study assessments and clinical interviews, including a 15-item scale of Dissociative Experiences during Sexual Behavior. Predictor variables included DSM-IV-TR diagnoses of PTSD and Dissociative Disorders, Rape by an Intimate Partner, Duration of CSA, Number of Perpetrators of CSA, and Current Sexual Satisfaction. A multiple regression analysis was conducted to identify significant associations between predictors and dissociation during sex. Mean differences by clinical diagnosis were also examined. Results

indicated that PTSD, Dissociative Disorders, Rape by an Intimate Partner, Duration of CSA, and Number of Perpetrators of CSA were associated with increased dissociation during sexual behavior. Dissociation during sex likely increases vulnerability to sexual revictimization and risky sexual behavior. Standard behavioral prevention interventions may be ineffective for sexual situations when dissociation occurs, and prevention efforts should be integrated with mental health care for those who have experienced CSA.

Psycho Sexual Therapy (Combined Therapy)

Althof, (1994) examined in his study titled "Sexual Therapy in the Age of Pharmacotherapy" that Combining medical and psychological interventions for individuals or couples with sexual dysfunction offers an alternative approach to therapy that enhances efficacy, treatment and relational satisfaction, and decreases patient discontinuation. By combining the power of both and changing the way we deliver psychological care, patients may, in the long-term, derive greater benefit. He reviewed the literature on combined therapy and propose one paradigm for combined therapy. This paradigm serves only as a model to be improved upon or extensively modified. Such combined treatment models must be conceptually sound and be subjected to reproducibility and sophisticated analysis. Psychological interventions combined with the use of sildenafil have been evaluated in two articles. In the first Melnik and Abdo (2005) randomly assigned men with psychogenic ED to one of three experimental groups. In Group 1, participants received 6 months of theme-based psychotherapy plus sildenafil 50mgs; in Group 2, they received only 50 mgs of sildenafil; in Group 3, they received only theme-based sexual counseling At the end of 6 months, compared to baseline, all three groups demonstrated significant improvement in post treatment International Index of Erectile Function (IIEF) scores.

However, utilizing the criterion of normalization of IIEF scores (EF domain ≥26), only the combined and psychotherapy only groups demonstrated statistically significant improvement.

Gupta & Banerjee et.Al (2002). conducted a study on 'Modified Masters - Johnson technique in the treatment of sexual inadequacy in males'. The objective was to examined the modification introduced into the M-J technique involves both its structure and function and the M-J technique was involved in any stage of treatment along with other psychotherapies. Study involved 21 married men were treated for erectile defect and premature ejaculation (both primary & secondary) by modified Masters-Johnson technique. Results came that 16(76.2%) has been recovered. The success rate was higher in secondary cases (83.3%). Best results were obtained in 30—39 yrs age group. The modified technique has been described to patients in detail. Factors favourable and unfavourable for success have been discovered.

Perelman, (2006) in his study titled "Premature Ejaculation: A Sex Therapist's Perspective" describes the diagnosis and treatment of premature ejaculation (PE) from a sex therapist's perspective and proposes that combination therapy integrating sex therapy and sexual pharmaceuticals is frequently the best treatment approach. Failure to appreciate the multimodal etiology and pathophysiology of PE makes the condition more difficult to diagnose and treat. Many physicians have tried pharmacologic approaches, but are limited to providing topical anesthetics or suggesting off-label uses of antidepressant and erectile dysfunction medications, because no medication is currently indicated specifically for PE. Furthermore, patients frequently relapse after discontinuation of the pharmaceutical. Sex therapists appreciate the multidimensional nature of PE for the patient and partner, but few patients seek out this approach, which is labor-intensive

and often lacking long-term follow-up success. Most men with PE are not receiving treatment, secondary to their embarrassment about discussing their condition and a lack of clinician inquiry about sexual dysfunction. Even for those who do engage in discussion, diagnoses may be inconsistent, because a universally accepted definition of the condition and diagnostic criteria are nonexistent. Besides increasing coital latency directly, sexual pharmaceuticals could be used to provide greater opportunity for men to recognize their premonitory sensations to ejaculation more readily, facilitating a "choice point", which is key to facilitating behavioral change and learning. Such a combination approach would result in prolonged ejaculatory latency, improved treatment satisfaction, and superior long-term outcome. Men with PE experience anxiety and lack sexual self-confidence; subsequently, their sexual and overall relationship frequently suffer. Because PE involves psychosocial and physiologic factors, treatment that addresses both should yield the best balance of function. Yet, a combination treatment integrating pharmaceuticals and sex therapy would provide an optimized approach.

Peter et al. (2008) in their study Title “Perspectives of Sex therapy outcome” found that randomly selected members who reported that the conduct sex therapy responded to a questionnaire about their sex therapy caseloads. Desire discrepancies between partners were the most common problem (31 %). Least commonly reported problems were vaginismus (5 %), ejaculatory inhibition (5 %), and primary erectile dysfunction (2 %). Highest success rates (client satisfaction with self-functioning) were for premature ejaculation (62 %), secondary orgasmic dysfunction (56 %), and desire discrepancies (53 %). Primary erectile dysfunctions had the lowest success rate (25 %). The most commonly used treatment methods were a focus on communication skills, general sex education, homework assignments, and a focus on the sexual

interaction; sensate focus and relationship issues also were quite commonly used. From a discrimination analysis, the combined Therapists and Multiple-certified provider groups reported focusing on sexual interactions more than the combined Counsellors and Educators; the Educators were the least likely providers to use a focus either on sexual interactions or on homework assignments. Therapists and Multiple-certified providers reported spending more treatment hours with desire discrepancies and desire problems. The implications of the findings for clinical practitioners and researchers are discussed.

Carufel & Trudel (2009) studied "Effects of a New Functional-Sexological Treatment for Premature Ejaculation". Various treatments have been developed to increase control over the moment of ejaculation, with two of the most frequent techniques used in behavior therapy being the squeeze method developed by Masters and Johnson (1970) and the "stop-and-start" technique described by Semans (1956). These treatments are effective and improve matters in most cases. However, couples can be averse to using them, with some women reluctant to squeeze their partner's penis and some couples unwilling to interrupt sexual interaction once initiated. Under a new functional-sexological treatment intended to improve control over the moment of ejaculation, men learn how to control their arousal without having to interrupt sexual activity. In this study, they compared three groups of couples in which the man suffered from premature ejaculation. One followed the new functional-sexological treatment, another followed a behavioral treatment—including the squeeze and stop-and-start techniques—and a control group was placed on a waiting list. They used several questionnaires to assess the effects of the various treatments. Moreover, subjects provided an objective measure of duration of intercourse from penetration to ejaculation. These measures were taken pre- and post-treatment and at three-month

follow-up. The methods used were analyses of variance to assess the effects of the treatments. Results indicate that the new treatment is very effective. We observed significant improvements in duration of intercourse, sexual satisfaction, and sexual functioning. The subjects in the behavioural treatment group obtained similar results. Furthermore, subjects from both groups were satisfied with their respective treatment.

The study titled “Psychosexual therapy for premature ejaculation” studied by **Althof, (2016)** that PE is not one disorder but includes the four subtypes (lifelong, acquired, natural and subjective) each with unique psychological concerns and issues. Psychological treatment for men and couples with PE addresses sexual skills/techniques but also focuses on issues of self-esteem, performance anxiety and interpersonal conflict. The outcome studies for psychotherapy alone are difficult to interpret and compare because of poor methodological design (lack of control groups, small sample size, poor outcome measures and lack of follow-up). However, the few studies that surmount these methodological hurdles suggest that psychological intervention offers men and couples a promising treatment option. Combination pharmaco- and psychotherapy is the most promising intervention for lifelong and acquired PE and offers superior efficacy to drug alone. This is because men and couples learn sexual skills, address the intrapsychic, interpersonal and cognitive issues that precipitate and maintain the dysfunction.

Althof, S. E. et al. (2014). An Update of the International Society of Sexual Medicine's Guidelines for the Diagnosis and Treatment of Premature Ejaculation (PE). The aim of this study was to develop clearly worded, practical, evidenced-based recommendations for the diagnosis and treatment of PE for family practice clinicians

as well as sexual medicine experts. Method used was a comprehensive literature review was performed. Results came that this article contains the report of the second ISSM PE Guidelines Committee. It offers a new unified definition of PE and updates the previous treatment recommendations. Brief assessment procedures are delineated, and validated diagnostic and treatment questionnaires are reviewed. Finally, the best practices treatment recommendations are presented to guide clinicians, both familiar and unfamiliar with PE, in facilitating treatment of their patients. Conclusion was the development of guidelines is an evolutionary process that continually reviews data and incorporates the best new research. We expect that ongoing research will lead to a more complete understanding of the pathophysiology as well as new efficacious and safe treatments for this sexual dysfunction.

Love Attitude

Sprecher, S. & Fehr, B. (2005). Compassionate love for close others and humanity. A compassionate love scale was developed that can be used, in alternative forms, to assess compassionate or altruistic love for different targets (e.g., close others and all of humankind). Using three samples (total N = 529), the Compassionate Love scale was developed and piloted. Three studies (total N = 700) were then conducted to provide validation of the scale and to examine correlates of compassionate love. In support of our predictions, compassionate love was found to be associated positively with prosocial behavior, as directed both to close others and to all of humanity. Those who were more religious or spiritual experienced more compassionate love than those who were less religious or spiritual. Evidence was found that compassionate love is distinct from empathy. In the final study, we introduced a relationship-specific version of the Compassionate Love scale, and found that compassionate love for a

specific close other was associated with the provision of social support for that person.

Feeney, J. A. & Noller, P. (1990). Attachment style as a predictor of adult romantic relationships. Questionnaire measures of attachment style, attachment history, beliefs about relationships, self-esteem, limerence, loving, love addiction, and love styles were administered to 374 undergraduates. Attachment style was related in theoretically expected ways to attachment history and to beliefs about relationships. Securely attached Ss reported relatively positive perceptions of their early family relationships. Avoidant Ss were most likely to report childhood separation from their mother and to express mistrust of others. Anxious ambivalent subjects were less likely than avoidant Ss to see their father as supportive, and they reported a lack of independence and a desire for deep commitment in relationships. The self-esteem measure and each of the scales measuring forms of love were factor analyzed separately. Analyses based on scale scores derived from the resulting factors indicated that attachment style was also strongly related to self-esteem and to the various forms of love discussed in other theoretical frameworks. The results suggest that attachment theory offers a useful perspective on adult love relationships.

Hazan, C. & Shaver, P. (1987). Romantic love conceptualized as an attachment process. This study explores the possibility that romantic love is an attachment process--a biosocial process by which affectional bonds are formed between adult lovers, just as affectional bonds are formed earlier in life between human infants and their parents. Key components of attachment theory, developed by Bowlby, Ainsworth, and others to explain the develoment of affectional bonds in infancy, were translated into terms appropriate to adult romantic love. The translation centered on the three major styles of attachment in infancy--secure, avoidant, and

anxious/ambivalent--and on the notion that continuity of relationship style is due in part to mental models (Bowlby's "inner working models") of self and social life. These models, and hence a person's attachment style, are seen as determined in part by childhood relationships with parents. Two questionnaire studies indicated that (a) relative prevalence of the three attachment styles is roughly the same in adulthood as in infancy, (b) the three kinds of adults differ predictably in the way they experience romantic love, and (c) attachment style is related in theoretically meaningful ways to mental models of self and social relationships and to relationship experiences with parents.

Marital Adjustment

Kumar, P. Avasthi, A. & Basu, D. Distress in wives of patients with psychosexual dysfunction: An exploratory study (1999), conducted with the aim of studying the wives of patients with psychosexual dysfunction with regard to the level of distress experienced and its relationship with their psychosocial dysfunction and marital adjustment. The sample comprised wives of 30 male patients with psychosexual dysfunction. Majority of the subjects was under matriculate, housewives, Hindus, and of urban background. Majority of their husbands suffered from combination of premature ejaculation and failure of genital response (60%). The subjects were found to be significantly more distressed, exhibited mild degree of psychosocial dysfunctioning. However, they had normal marital adjustment. The interrelationship between these three variables showed significantly positive correlation between distress and psychosocial dysfunction. Marital adjustment showed significant negative correlation with both the distress experienced and

psychosocial dysfunctioning. These findings not only have implication for the management of these disorders, but may have prognostic value as well.

A. Avasthi, S. Sarkar, S. Grover. (2015). A perspective on Marital and Psychosexual Disorders in India. This chapter takes an overview of the various aspects of marital and psychosexual disorders, especially with reference to the Indian scenario. Sexual dysfunction is seen in about one-tenth of patients visiting the psychiatric outpatient clinics, with premature ejaculation, erectile dysfunction and the Dhat syndrome being the most common sexual disorders. Studies suggest that sexual dysfunction is also highly prevalent in specialised groups like opioid- and alcohol-dependent patients and those receiving psychotropic medications. In general, patients in the Indian setting have poor sexual knowledge and conservative attitude towards sex. These variables have an impact on treatment adherence and overall outcome of sexual dysfunction. Studies have also attempted to characterise the phenomenological expression of the Dhat syndrome and have designed treatment packages to manage these patients. Studying the impact of sexual dysfunction on spouses has shown that sexual dysfunction among men has significant psychosocial impact on their partners too. Research that has focused on female sexual health issues has demonstrated that many female patients receiving psychotropic medications suffer from sexual dysfunction. However, the research and development of services in this area is still preliminary and scarce.

Kendurkar, A., Kaur, B., Kumar, A., Singh, H., & Agarwal, V. (2008). Profile of Adult Patients Attending a Marriage and Sex Clinic in India. Sexual disorders, which are usually influenced by multiple factors, are very prevalent across the globe but there are few studies which provide the pattern of help-seeking behavior in the Indian population. The study aims to present the pattern of sexual dysfunction in the

patients attending a marriage and sex clinic from 1979 to 2005. The details were obtained from the records of the patients who attended the clinic. In accordance with the change in diagnostic classification, the data were presented: ICD-IX (for period 1979—1992) and ICD-X (for period 1993—2005). Results obtained were out of a total of 1,242 patients, 566 patients attended the clinic during 1979 to 1992, and 676 patients during 1993 to 2005. More than half of the clinic population during the period was aged 20—29 years. Premature ejaculation is the most common complaint and the most commonly diagnosed clinical entity, followed by male erectile problems and culturally induced sexual behaviors such as dhat syndrome. Being more educated, married and from an urban background promotes help-seeking in tertiary care clinics but these findings may be due to selection bias. Sexual activity continues to be strongly influenced by culturally held beliefs. This influence is more troublesome for young and unmarried persons who have not changed over the period.

Guilt

Children's Proneness to Shame and Guilt Predict Risky and Illegal Behaviors in Young Adulthood study done by Stuewig, J., Tangney, J., Kendall, S., Folk J., Meyer C., R., Ronda L. (2016) that Do shame and guilt help people avoid doing wrong? Although some research suggests that guilt-proneness is a protective factor while shame-proneness puts individuals at risk, most research is either cross-sectional or short-term. In this longitudinal study, 380 5^{th} graders (ages 10–12) completed measures of proneness to shame and guilt. We re-interviewed 68% of participants after they turned 18 years old (range 18–21). Guilt-proneness assessed in childhood predicted fewer sexual partners, less use of illegal drugs and alcohol, and less involvement with the criminal justice system. Shame-proneness, in contrast, was a

risk factor for later deviant behaviour. Shame-prone children were more likely to have unprotected sex and use illegal drugs in young adulthood. These results held when controlling for childhood SES and teachers' ratings of aggression. Children's moral emotional styles appear to be well established by at least middle childhood, with distinct downstream implications for risky behavior in early adulthood.

Sheikh S1, Janoff-Bulman R. (2009) A self-regulatory framework for distinguishing between shame and guilt was tested in three studies. Recently, two forms of moral regulation based on approach versus avoidance motivation have been proposed in the literature. Proscriptive regulation is sensitive to negative outcomes, inhibition based, and focused on what we should not do. Prescriptive regulation is sensitive to positive outcomes, activation based, and focused on what we should do. In the current research, consistent support was found for shame's proscriptive and guilt's prescriptive moral underpinnings. Study 1 found a positive association between avoidance orientation and shame proneness and between approach orientation and guilt proneness. In Study 2, priming a proscriptive orientation increased shame and priming a prescriptive orientation increased guilt. In Study 3, transgressions most apt to represent proscriptive and prescriptive violations predicted subsequent judgments of shame and guilt, respectively. This self-regulatory perspective provides a broad interpretive framework for understanding and extending past research findings.

Tangney JP, Wagner PE, Gramzow R. Proneness to shame, proneness to guilt, and psychopathology (1992). The relation of shame and guilt to anger and aggression has been the focus of considerable theoretical discussion, but empirical findings have been inconsistent. Two recently developed measures of affective style were used to examine whether shame-proneness and guilt-proneness are differentially related to anger, hostility, and aggression. In 2 studies, 243 and 252 undergraduates

completed the Self-Conscious Affect and Attribution Inventory, the Symptom Checklist 90, and the Spielberger Trait Anger Scale. Study 2 also included the Test of Self-Conscious Affect and the Buss-Durkee Hostility Inventory. Shame-proneness was consistently correlated with anger arousal, suspiciousness, resentment, irritability, a tendency to blame others for negative events, and indirect (but not direct) expressions of hostility. Proneness to "shame-free" guilt was inversely related to externalization of blame and some indices of anger, hostility, and resentment.

CHAPTER-III

METHODOLOGY

Rational of the Study

The rational of my study would suggests that combined Cognitive Behaviour Therapy and sex therapy treatment results in improved efficacy of the marital disharmony and creates a positive love attitude towards each other in relationship, decreased dissatisfaction among them, and enhanced better sexual dysfunction treatment of PE and sexual satisfaction.

This study would help in providing combined treatment to patient's challenges therapists to move beyond traditional postures and paradigms and to work with, rather than in opposition to, or independent of, medical providers. Such combined treatment models found to be conceptually sound and would subject to reproducibility and sophisticated analysis. Combination therapy, if proven useful, may be one answer to challenge to develop fresh and innovative treatments for sexual problems (Schover and Leiblum's ,1994). In the future, pharmaceutical interventions for sexual dysfunction i.e PE would likely be improved in combination with psychological therapies such as CBT and sex therapy.

This study also helps the various clinicians to stand ready to consider combined therapy for PE and to test models and interventions for these problems. As the field develops, paradigms and techniques of combined therapy (CBT & Sex Therapy) will hopefully evolve and become the future standard of care for treating male sexual dysfunction.

AIMS AND OBJECTIVES

1. To evaluate the effectiveness of CBT on variables of the study (viz, Love Attitude, Marital Adjustment and Guilt) among the patients with PE.

2. To evaluate the effectiveness of ST on variables of the study (viz, Love Attitude, Marital Adjustment and Guilt) among the patients with PE.
3. To evaluate the effectiveness of CBT+ST on variables of the study (viz, Love Attitude, Marital Adjustment and Guilt) among the patients with PE.
4. To compare the post test scores of CBT, ST and CBT+ST on the variables of the study (viz, Love Attitude, Marital Adjustment and Guilt) among the patients with PE.
5. The evaluate the pre and post scores in control group on the variables of the study (viz, Love Attitude, Marital Adjustment and Guilt) among the patients with PE.
6. To evaluate the relapse prevention in all the treatment groups and control group.

HYPOTHESES

H1: The pre and post test scores with CBT as intervention will differ significantly on the measures of Love Attitude, Marital Adjustment, and Guilt among the patients with PE.

H2: The pre and post test scores with ST as intervention will differ significantly on the measures of Love Attitude, Marital Adjustment, and Guilt among the patients with PE.

H3: The pre and post test scores with CBT +ST as intervention will differ significantly on the measures of Love Attitude, Marital Adjustment, and Guilt among the patients with PE.

H4: The post test scores on the intervention CBT, ST and CBT+ST will differ significantly on the measures of the study viz, Love Attitude, Marital Adjustment and Guilt among the patients with PE.

H5: There will be no difference in the pre-post scores of PE, Love Attitude, Marital Adjustment and Guilt in the control group on the variables of the study viz, Love Attitude, Marital Adjustment and Guilt among the patients with PE.

H6: To study the effectiveness of the 4 groups (viz, CBT, ST, Combined ST+CBT and control group) in terms of Relapse Prevention.

OPERATIONAL DEFINITION OF THE VARIABLES

Independent variables

• **CBT**: Dr. Aaron T. Beck, CBT is a form of psychotherapy, in which therapist and the client work together as a team to identify and solve problem. In this the negative patterns of thought about the self and the world are challenged in order to alter unwanted behavioural patterns or treat mood disorder, that is, the therapist (investigator) help clients overcome their difficulties by changing their difficulties by changing their thinking, behaviour and emotional responses.

• **ST**: Sex Therapy is a specialised form of psychotherapy developed my Masters & Johnson. Sex therapy is a strategy for the improvement of sexual function and treatment of sexual dysfunction. This includes sexual dysfunctions such as premature ejaculation or delayed ejaculation, erectile dysfunction, lack of sexual interest or arousal, and painful sex (vaginismus and dyspareunia). It includes dealing with problems imposed by atypical sexual interests (paraphilias), gender dysphoria and being transgender, very high sex drive or hypersexuality, a lack of sexual confidence, recovering from sexual assault, and sexual issues in aging, illness, or disability.

• **COMBINED CBT AND ST**: combining both the processes CBT and ST together from the beginning of the sessions.

Dependent variables

- **PE**: Premature Ejaculation is a male sexual dysfunction characterised by ejaculation that always or nearly always occurs prior to or within about one minute of vaginal penetration. The inability to delay ejaculation on all nearly all vaginal penetrations.

Negative personal consequences such as distress, bother, frustration and the avoidance of sexual intimacy.

- **Love Attitude**: Love Attitude is a psychological construct, a mental and emotional entity that inheres in, or characterizes a person. They are complex and are an acquired state through experiences. It is an individual's predisposed state of mind regarding a value and it is precipitated through a responsive expression towards a partner, place, thing, or event (the attitude object) which in turn influences the individual's thought and action towards each other partner. These love style may change over a lifetime, but not always. These different categories of love attitude give a sense of the kind of lover you tend to be and how it effects sexual intimacy between couples and PE, even if you are not in a relationship right now. If someone is in a relationship, love attitude help describe what you are like and how you behave in that relationship.
- **Marital Adjustment**: Marital adjustment has long been used to describe the quality and stability of marriage. A well-adjusted marriage is expected to last for a long time and be satisfying by both spouses. The quality of marital relationship has been found to be consequential for health. A poor marital relationship could influence physiological functions and impact health outcomes through depression and health habits The process during which partners in a marriage adapt and change to their new roles complementing each other acting as a team opposed to two separate units, it is also important to unify the following- interests and values, maintaining open lines of communication mentally and sexually and encouraging the expression of each other's communication. Marital adjustment, "shortly after 'tying the knot' the new couple will enter into marital adjustment where they will establish their place within the relationship found their feet in the new life." If the adjustment leads to some

causes in their lifestyle then it can lead effect their sexual intimacy and can cause various sexual dysfunction.

- **Shame and Guilt**: Shame and guilt are crucial emotions regulating individuals' interactions with the surrounding environment as well as social relations and the development of self. However, regardless of their importance. The shame and guilt are separate emotions with different implications for psychological adjustment. While guilt appears when individual's an adverse outcome to unstable internal causes (e.g. "I didn't try hard enough"), in contrast, shame is more linked to stable internal causes (e.g. "I am a dumb person"). Feelings of shame and guilt are often accompanied by a sense of shrinking or of being small and by a sense of worthlessness. Therefore, PE can be correlated with shameful feelings and with the desire to move away from the negative situation.
- **Relapse Prevention**: "Relapse prevention includes planning and commitment to following that plan. Because there are numerous warning signs before a relapse, a key part of a relapse prevention plan is being honest about what events might trigger a relapse, and determining how to respond ahead of time. Reviewing potential relapse triggers and appropriate responses is something that should include those aiding the recovery effort." Patients will be considered as relapse who SCS scores will increase from their remission status score after completion of an adequate trial.

Sample Description

The sample size of the study consisted of 40 PE patients. 10 participants constituted each group viz ST, CBT, combined ST and CBT and Control Group. The participants would be selected from Bhandari Hospital and Research Centre (IASH department) OPD.

A (ST)	**B (CBT)**	**C (Combined ST+CBT)**	**D (Control Group)**	**Total**
10	10	10	10	40

In the present study purposive sampling would be used. Participants would voluntary get selected and anonymity would be maintained. 40 clients would be selecting for the study. These participants receive the treatment at the same time. 5 extra clients would be selected in each treatment group in order to protect against potential dropout. The clients would be required to meet a number of criteria.

Inclusion Criteria

1. 18 years and above

2. Knowledge of English and Hindi language

3. Stable on medications for a minimum period of 1month

4. Either free of psychoactive medication or on a stable medication regimen for at least a month prior to baseline assessment and willingness to refrain from making any medication changes throughout treatment.

Exclusion Criteria

1. Co-morbid psychiatric disorder and neurological disorders (psychosis, bipolar affective disorder, severe D with psychotic symptoms, current psychoactive substance abuse or dependence, mental retardation, epilepsy, head injury and other neurological disorders), and Patients who had received any adequate trial (5-8 sessions) of cognitive behavior therapy and sex therapy in the previous year.

2. Or has undergone any type of therapeutic process.

CONTROLS

• To control the bias the tests would be administered in random order.

• To control extraneous variables all the testing work will be carrying out by the investigator herself.

• Before administering the tests the participants would be informed that the results would be kept confidential and would be used for research purpose only.

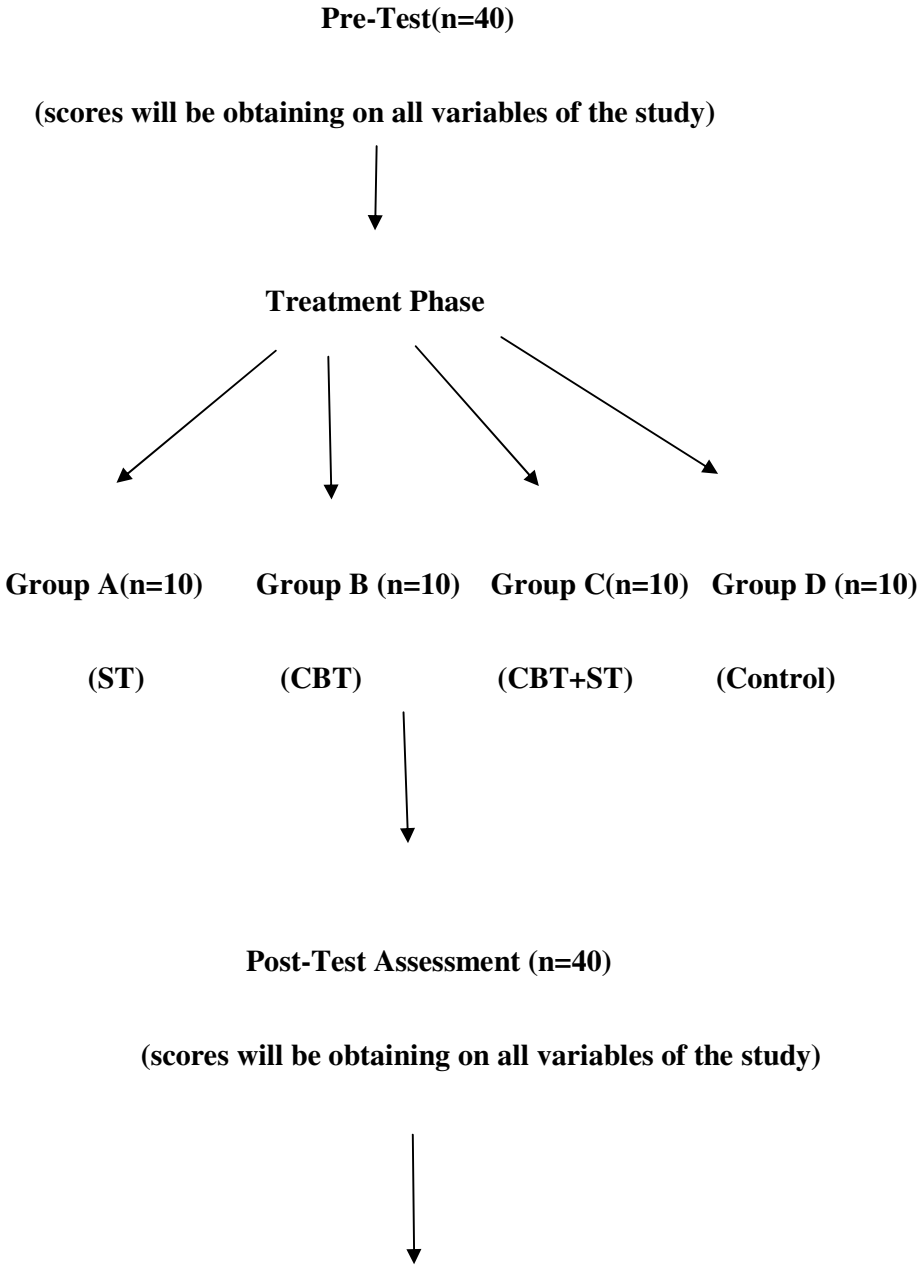
• Recipients of intervention will not receive any other professional help (in terms of therapeutic help) during the course of study.

Research Design

The study would be conducting based on Pre-Post Research Design

Group	**Pre-Assessment**	**Intervention**	**Post-Assessment**	**Results**
A(ST)		ST		
B(CBT)		CBT		
C (Combined ST and CBT)		ST and CBT		
D(Control)		No intervention		

RESEARCH PLAN


Pre-Test(n=40)
(scores will be obtaining on all variables of the study)
Treatment Phase
Group A(n=10) (ST)
Group B (n=10) (CBT)
Group C(n=10) (CBT+ST)
Group D (n=10) (Control)
Post-Test Assessment (n=40)
(scores will be obtaining on all variables of the study)
Assessment at 2 months post intervention for relapse assessment(n=40)

TOOLS OF THE STUDY

a. **Social demographic and clinical data sheet:** This data sheet would be use to obtain social demographic details of the patient i.e., age, and education, and socioeconomic status and clinical data of the patient including the chief complaints, history of presenting illness, pre‐morbid personality and the diagnosis made by a qualified andrologist.

b. **Semi‐structured interview schedule**: A semi‐structured interview schedule would develop that include details of patient's sexual experiences like sexual experiences, masturbation, nocturnal emissions and, duration, frequency, other associated problems, causative factors as believed by the patient and sources of information for his sexual knowledge.

c. **Sexual Complaints for Men (SCS-M) -** The Sexual Complaints Screener for Men (SCS-M) has been developed by the Standards Committee of the International Society for Sexual Medicine. It is a comprehensive self-report screener for sexual dysfunction that can be easily and quickly administered by non-specialized clinicians and addresses all domains of sexual dysfunction, including distress. The screener intends to cover sexual desire/interest, objective and subjective arousal, orgasm, pain, vaginismus, persistent genital arousal disorder and satisfaction with one's sex life. This brief, self-administered screener is neither sufficiently detailed for obtaining an adequate diagnosis, nor is it constructed to provide end points for specific clinical trials. The SCS consists of a series of questions concerning sexual experiences during the last six months.

d. **Love Attitude Scale (Hendrick & Hendrick, 1986). -** A 42-item questionnaire designed to measure attitudes toward love. The questionnaire combines attitudes toward one's current/recent/hypothetical** partner with attitudes about love in general. The scale is broken into 6 subscales consists of 7 items each, that each represents a different love style: EROS (passionate love), LUDUS (game-playing love), STORGE (friendship love), PRAGMA (practical love), and MANIA (possessive, dependent love), AGAPE (altruistic love). Participants respond to each item using a 5-point scale, ranging from 1 (strongly agree), 2 (Moderately agree), 3 (neutral), 4 (moderately disagree), 5 (strongly disagree). Participants are instructed to answer questions with their current partner in mind. However, the instructions state that if the respondent does not currently have a partner, he or she should answer with their most recent partner in mind. If, however, the respondents have never been in love, the instructions state that they should provide whatever answer they believe would be true. Reliability by the method of internal consistency of the six factors is .62 to .85; while

the stability coefficients for test- retest method is .44 to .77. The six factors has a good structural validity.

e. Short Marital Adjustment Test (Locke, H. J., & Wallace, K. M, 1959). Short Marital Adjustment test (LWSMAT) is a 15-item self-administered test that can be completed in approximately 5 min. It can also be administered by the interviewer through telephone. It is available in a paper-and-pencil format and an electronic edition. The first item of the test measures global happiness; the next 8 items address agreement on specific matters such as finances, recreation, affection, friends, and philosophy of life; and the remaining 6 items address specific choices and feelings regarding the marriage and the respondent's spouse. The test use various response formats, including 7-point (Item 1), 6-point (Items 2–9), and 4-point (Items 11, 13, and 15) Likert-type scale, and 3- and 2-choice responses (Items 10, 14, and 12). A complex scoring system is used in the LWSMAT, including 10 different weights for all 15 items. For example, the scoring of Item 12 depends on the agreement between the spouses. It is calculated as 10 = stay at home for both, 3 = on the go for both, and 2 = disagreement. The total scores are the sum of each item and range from 2 to 158. Reliability was found to be .90 using the split-half technique and corrected by the Spearman-Brown formula, indicating that this scale has high internal consistency. Validity was supported by a significant difference between well-adjusted and maladjusted groups re-examined the reliability of the LWSMAT and did not get the same high reliability (Cronbach's alpha = 0.77). The range of reliability has been reported as 0.72–0.83

f. State Shame and Guilt Scale (SSGS)- Marschall, Saftner & Tangney (1994) developed the State Shame and Guilt scale. The SSGS is a self-rating scale of in-the-moment (state) feelings of shame, and guilt experiences. Ten items (five for each of the two subscales) are rated on a 5-point scale Likert scale. The following are some statements which may or may not describe how you are feeling right now. Individuals rate each statement using the 5-point

scale. Each statement based on how the individuals are feeling right at the moment. Scoring Each scale consists of 5 items: Shame - Items 1, 3, 5, 7, 9 and Guilt - Items 2, 4, 6, 8, 10. All items are scored in a positive direction. Internal consistency reliability of the Shame and Guilt scale is a value between .70 and .79.

PROCEDURE

The study would be conducted in two phases, namely, the Pilot and the Main study.

Pilot Phase

The purpose of doing pilot study is: -

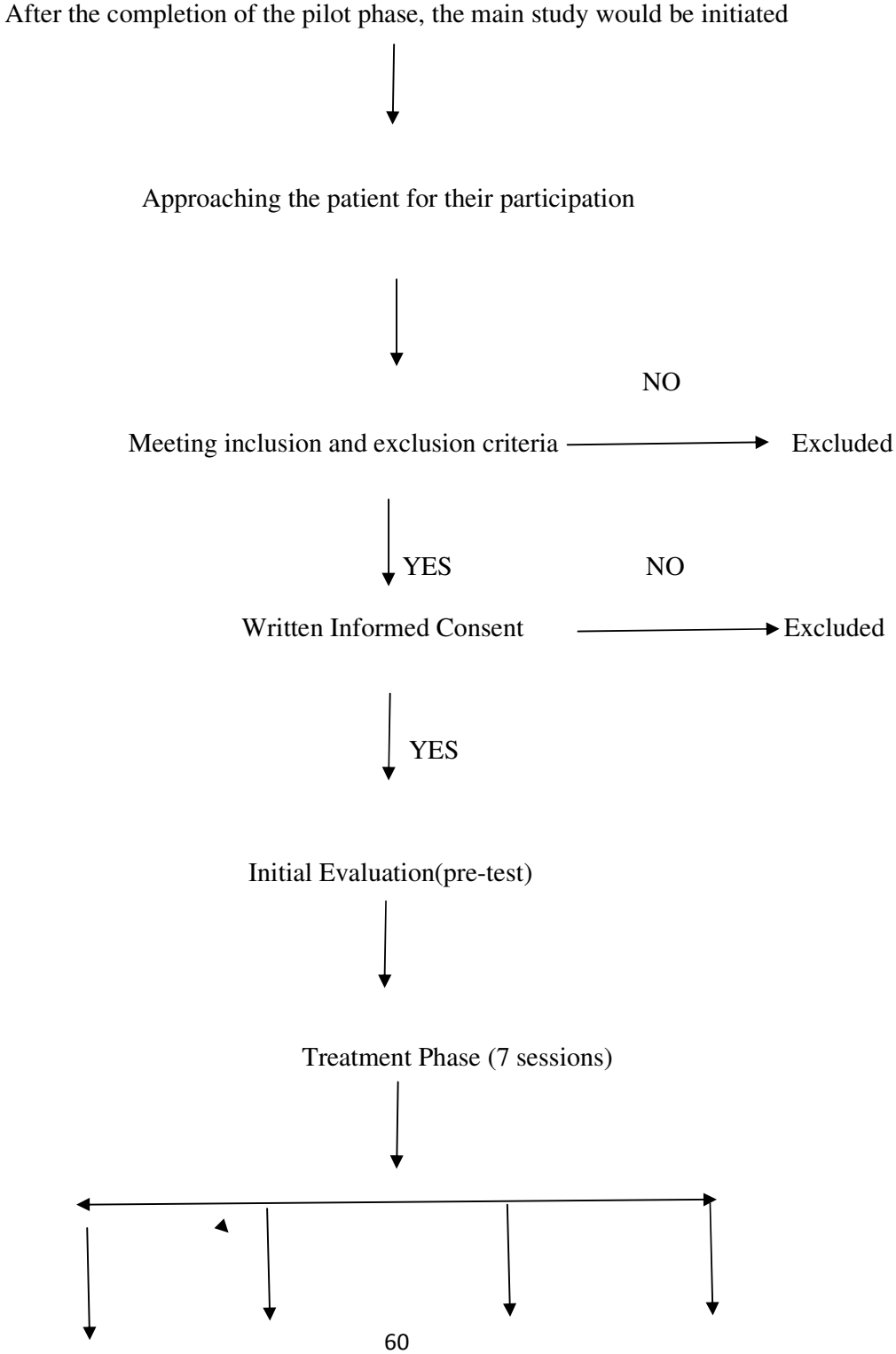
1. To ensure the feasibility of the tools selected for the sample of the study.
2. For the researcher to gain familiarity and expertise in the administration, scoring and interpretation of the tools.
3. To finalizing the tools for the main study.
4. To know the average time in which the assessment can be conducted.
5. To know about the psychological mindset of the patients.

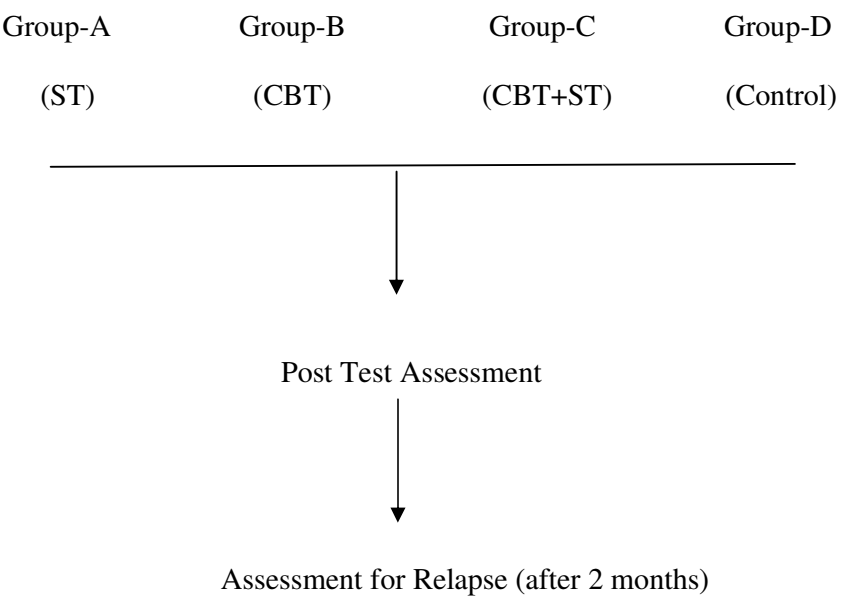
During the pilot phase three to four patient would be diagnosed with PE would be selected from the OPD of Bhandari Hospital and Research Centre, Jaipur after taking permission from the hospital administration. Then these cases would be assessed using the measures of the study (viz, SCS-M, Love attitude scale, Marital Adjustment Test, State Shame and Guilt Scale) after that the cases would be recruited in all the 3 treatment conditions and control group. Adequate trial of ST, CBT and Combined ST and CBT would be administered. Baseline and post assessment would be carried out.

Main Study

After the completion of the pilot phase, main study would be initiated. Cases of pilot study would not be including in the main study.

Main Study Plan





Measurement Schedule

The six instruments (Socio-demographic and Clinical Data Sheet, SCS-M, Love Attitude scale, Marital Adjustment test and State Shame and Guilt scale.) would be administered during the initial evaluation to determine a baseline measure prior to the commencement of treatment. Then the again six measures would be re-administered at the end of the treatment that is in the 7th session. Then SCS-M was again re-administered at 2 months post treatment to evaluate relapse.

STATISTICAL ANALYSIS

1. Mean
2. Standard Deviation
3. Kurskal-Wallis H Test
4. Paired sample t-test

SPSS 22 would be used to analyse the data.

ETHICAL CONSIDERATIONS

• Written informed consent would be obtained from all the patients for their participation in the study.

• Patients would be informed that they have the option to discontinue from the therapeutic program at any point of time and this would not influence their medical treatment.

• Confidentiality is assured and maintained.

• Patients who did not improved after the planned completion of therapeutic program, therapy would continue after the follow up assessment.

• The hospital management would be informed about the implications of the study.

• The patients would be informed that they could contact the investigator in case they need any psychological help.

Conclusion

- The study focuses on the effectiveness of CBT, ST, Combined CBT and ST in the treatment of PE patients along with variables of the study: love attitude, marital adjustment and guilt.
- Various psychological variables are responsible in developing Premature ejaculation in male. It requires combined psychosexual treatment to reduce the severity of PE.

Appendices

Appendix-A

CBT intervention module

The module consisted of the following components:

a. **Intake and assessment** (Sessions 1): A detail phenomenological account of the patient's difficulties would obtain. The patient's own formulation of his problems is understood. Baseline data is obtained through administration of tools.

b. **Socializing the patient to CBT** (Sessions 2): A working alliance is established with the patient. The patient is socialized to the style of CBT. The patient is provided a generic Cognitive behavioral model of psychological disorders. He is helped to conceptualize his problems from a Cognitive Behavioral perspective.

c. **Basic sex education** (Sessions 3): Sex education involves human sexual processes sexual anatomy and physiology (including production of semen) using pictures and photographs. Patient is explained about the various causes of premature-ejaculation. It would also help them clarify their beliefs and misconceptions about sexual dysfunctions and their specific interventions.

d. **Cognitive restructuring and other techniques** (Sessions 4 to 6):

Cognitive restructuring: Patients with PE readily attribute their symptoms to misconceptions and lack of proper knowledge without consideration of alternative explanations. Cognitive distortions/errors like selective attention, catastrophisation and personal beliefs result in the augmentation and maintenance of somatic, sexual and other symptoms. The symptoms are thus attributed to PE rather than to emotional and subjective factors. They may have core beliefs about masculinity, sexual power and so forth. The automatic thoughts that the patient experiences are elicit using thought listing and thought diary methods. Various standard

methods of cognitive restructuring are used to modify the patient's cognitions and beliefs about his condition. Importance of emotional and relationship factors in sexual relations would explain. Since these patients are concerned about 'sexual power and performance', they experience immense performance anxiety during the sexual act. They would explain how performance anxiety hampers sexual performance. The schema of 'masculinity' has to be addresses specifically. These patients believe that 'masculinity' is intrinsically related to 'sexual power'. It is important to modify this strong belief.

• **Masturbation as homework**: Although the clients could understand the harmlessness of PE intellectually after Basic Sex Education, they find it difficult to re-engage in sexual activities. This aims at an emotional and experiential learning of the harmlessness of PE. The therapist can guide them through the process of identifying cognitive errors and restructuring them. Principles of sensate focus can be incorporated to reduce the anxiety surrounding PE.

e. Termination (Session 7**):** The patient would ask to summarize the sessions and therapy. The concluding sessions focus on preparation of the patient for future, re-emphasizing his new learning and reiterating the principles of self-awareness and self management.

Appendix B

Sex-Therapy Intervention Module

Sex therapy or see couples and individuals, we are likely to come across couples struggling with issues related to sex. This module can help you improve couples skills and better help those clients.

a. **Psycho-education (Session-1) -** Psycho education about the illness and its evidence based therapeutic intervention for patients and their family members that provide information and support to better understand and cope with illness.
b. **Sensate and Non-sensate techniques (Session-2) -** The second session starts with the sensate focus following with non-sensate focus techniques.

Sensate Focus- The aim of sensate focus is to build trust and intimacy within a relationship, helping to give and receive pleasure. It emphasizes positive emotions, physical feelings and responses while reducing any negative reactions. The module can help overcome any fear of failure that may have existed previously, building a more satisfying sexual relationship in which both partners feel able to ask for what they wanted are able to give and receive pleasure. Sensate focus is not a race to an end. Continuous Reinforcement is needed to overcome negative reactions to intimacy. Typically, sessions last twenty to forty five minutes, one or two times a week.

Instructions

1. When it is your turn to touch, take plenty of time to explore the other person's body. Experiment with different sensations and types of touch. Take pleasure in experiencing the texture, form and temperature of the other person's body.

2. Try to discover the degrees of pressure and types of touch your partner finds most appealing by encouraging feedback or by placing your hand under their hand so they can show you what they want.
3. When it is your turn to be touched, make sure you let the other person know what you like and what you don't. You can tell your partner how you feel, make appreciative noises, or move their hand to where you want to be touched.
4. Avoid saying, 'don't...' as it can be discouraging. It's more encouraging to say things like 'it feels better when you....'
5. You might find it useful to talk about your experiences afterwards, e.g. 'I really liked it when you…' If there is something you would like to try, don't be afraid to suggest it.

Non-genital Sensate Focus: (Session-3) - At this stage, avoid touching the obvious erogenous zones: breasts, nipples, vulva, clitoris or vagina, penis or testicles. Only move from state to the next when both individuals feel ready. Sexual intercourse and orgasm are not permitted during this phase. A book or DVD about massage can be useful, and helpful in learning different techniques.

Instructions

- During first sessions concentrate on touching the parts of the body normally visible: the hands, arms, feet, scalp and face.
- When you are ready, include the back, neck, arms, buttocks and legs, not neglecting the hands, feet and face.
- Finally bring in the chest, stomach, shoulders and thighs, but avoid the breasts, tops of legs and the groin area.

Session-4: Genital Sensate Focus- the main aim of these stages is to increase each person's pleasure and awareness of each other's responses to different types of stimulation. It's fine to become aroused, but this is not the aim of the exercise. During genital stimulation it is often useful to use a water-based lubricant. Oil-based products should not be used near condoms. Sexual intercourse and penetration is not permitted during this phase.

Instructions:

- First incorporate touching of breasts and nipples. Remember, men have nipples too.
- Next include the areas around the genitals, including the testicles of a man. Then introduce touching of the genitals themselves (the labia, clitoris and entrance to the vagina on a woman; the penis, shaft and glans on a man).
- After a while one may also want to incorporate oral as well as manual touching (kissing, licking and sucking) into both non-genital and genital touching.
- You may want to try (the 'teasing technique'. Manually stimulate the other person's genitals, gently at first then increase the speed of stimulation.
- Take a rest for a few minutes and then begin again. If orgasm occurs at this or later stages, that is fine, but that is not the aim of the process.

Session-5: Penetrative Sensate Focus

Ground Rules:

- Having spent some time on non-genital and genital sensate focus you can begin to include penetration, using fingers, toys and the penis.

- Continue to pay attention to the other parts of the body that you explored in the previous sessions.
- The person being penetrated should be in control of the depth of penetration and the amount of time spent on it.
- While orgasm and intercourse is permitted in this phase, this is not the goal: the aim remains to enjoy the growing intimacy between the partners.

Instructions:

- Remember to use a lubricant.
- First begin to incorporate forms of gentle penetration, initially try this with little or no thrusting, just enjoying the sensation of containment.
- Try it first with one person on top and then the other.
- Later you can incorporate more thrusting, again with the person being penetrated in control.

Appendix C

CBT+ST intervention module

a. Intake and Psychosexual Assessment (Session-1)

b. Basic Psychosexual Education (Session-2)

c. Cognitive Restructuring (Session-3)

d. Sensate & Non- Sensate techniques (Session-4)

e. Homework Assignments (Session-5)

f. Penetrative Sensate Focus (Session-6)

g. Termination & Feedback & Assessment (Session-7)

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- American Academy of Family Physicians/American Family Physician - Female Sexual Dysfunction: Evaluation and Treatment
- Association of Reproductive Health Professionals: Size Up Your Sex Life
- Planned Parenthood: Sex and Sexuality